health and housing form

UNIVERSITY OF THE CUMBERLANDS
WILLIAMSBURG, KENTUCKY 40769-1372
TOLL FREE 1-800-343-1609 TEL 606-539-4241 FAX 606-539-4303
WWW.UCUMBERLANDS.EDU

** Please Note ** Deposit must be paid before housing information is processed. As a full-time student at University of the Cumberlands, you must reside in college housing unless you meet one or more of the criteria for exemption.
If you wish to apply for exemption, please contact the Office of Admissions to obtain a Housing Exemption Form. Only those persons who are approved for exemption may reside off-campus.

❑ I intend to apply for housing exemption. (Complete personal information below and health information on back.)

STUDENT STATUS ❑ Freshman ❑ Transfer ❑ Re-entering ❑ Re-entering Transfer ❑ Special

DESIRED DATE OF ENROLLMENT: ❑ Fall 20_____ ❑ Spring 20____ ❑ Summer 20_____

PERSONAL INFORMATION

LAST NAME | FIRST | MIDDLE | PREFERRED NAME

HOME ADDRESS

CITY | COUNTY | STATE | ZIP

HOME PHONE | CELL PHONE | SEX | HEIGHT | WEIGHT

DATE OF BIRTH | **MARITAL STATUS** ❑ SINGLE ❑ MARRIED ❑ WIDOW (ER) ❑ DIVORCED ❑ SEPARATED

FAMILY DATA

FATHER'S LAST NAME | FIRST | MIDDLE | OCCUPATION

HOME ADDRESS

CITY | COUNTY | STATE | ZIP

HOME PHONE | OFFICE PHONE | CELL PHONE

MOTHER'S LAST NAME | FIRST | MIDDLE | OCCUPATION

HOME ADDRESS

CITY | COUNTY | STATE | ZIP

HOME PHONE | OFFICE PHONE | CELL PHONE

PARENTS' MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ WIDOW (ER) ❑ DIVORCED ❑ SEPARATED

EMERGENCY CARE

If my son, daughter, or ward (who is under eighteen) should become suddenly ill and need emergency surgical or medical care, and attempts to reach me to get my permission for such care have failed, I hereby give permission to give such emergency care until I can be reached.

_____ SIGNATURE OF PARENT/GUARDIAN

_____ FIRST WITNESS (NOT A RELATIVE)

_____ NAME OF APPLICANT

_____ SECOND WITNESS (NOT A RELATIVE)

(Please complete entire section.)

**** IMPORTANT** All roommates must request one another, and all requests must be received by June 1, or the request may not be honored.**

IF YOU HAVE A SPECIFIC ROOMMATE(S) REQUEST, PLEASE LIST THE NAME(S):

_____

YOUR RESPONSE TO THE ITEMS LISTED BELOW WILL HELP US IN MAKING YOUR ROOMMATE ASSIGNMENT.

PLEASE INDICATE ANY FACTORS THAT YOU BELIEVE NEED TO BE CONSIDERED IN MAKING YOUR ROOMMATE ASSIGNMENT.

_____

PREFERRED RESIDENCE HALL: 1_____ 2_____3_____

DO YOU SMOKE? (CIRCLE ONE) YES NO

WHAT MAJOR FIELD OF STUDY HAVE YOU SELECTED? _____

ARE YOU INTERESTED IN A PARTICULAR CLUB OR ORGANIZATION? IF SO, WHICH GROUP? _____

HAVE YOU BEEN RECRUITED TO PARTICIPATE IN INTERCOLLEGIATE SPORTS? IF SO, WHICH TEAM? _____

WHAT TYPE OF MUSIC DO YOU PREFER? _____

WHAT IS YOUR RELIGIOUS PREFERENCE? _____

HOW MANY HOURS OF STUDY TIME DO YOU NEED EACH NIGHT? (CIRCLE ONE) 2 4 6 8

HOW MANY HOURS OF SLEEP DO YOU NEED EACH NIGHT? (CIRCLE ONE) 4 6 8 10

HOW IMPORTANT IS HAVING A CLEAN ROOM TO YOU? (CIRCLE ONE) VERY SOMEWHAT NOT IMPORTANT

HOW IMPORTANT IS A QUIET ROOM TO YOU? (CIRCLE ONE) VERY SOMEWHAT NOT IMPORTANT

HEALTH INFORMATION

This information is used as an aid to providing necessary health care while you are a student and is only shared on a need-to-know basis.

DO YOU HAVE ANY HEALTH PROBLEMS? (CIRCLE ONE) YES NO
IF YES, PLEASE DESCRIBE _____

REQUIRED IMMUNIZATIONS **(Please include copy of official immunization record)**

PLEASE LIST DATE OF:
MMR (Measles, Mumps, Rubella): #1 _____ #2 _____
HEPATITIS B #1 _____ #2 _____ #3 _____
MENINGOCOCCAL _____
Vaccine Waiver

I have received and read the information provided by University of the Cumberlands explaining the risks of hepatitis B and meningococcal disease and the effectiveness of the vaccines. I acknowledge that meningococcal disease is a rare, but life-threatening illness. I understand that under University of the Cumberlands policy, students are required to be vaccinated against hepatitis B and meningococcal disease. With this waiver, I seek exemption from this requirement. I voluntarily agree to release, discharge, indemnify and hold harmless University of the Cumberlands, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my decision not to be immunized.

For individuals 18 years of age or older: Signature of student:_____Date:_____

For individuals under the age of 18: Signature of parent/guardian:_____Date:_____

DATE OF LAST: TB SKIN TEST DATE _____ RESULTS _____
(OPTIONAL) CHEST X-RAY DATE _____ RESULTS _____

Emergency contact other than parent or guardian:
Name _____ Phone # _____ Relationship _____